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WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS d/b/a REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; and LENDOL L. DAVIS, M.D., ON BEHALF OF THEMSELVES AND THEIR PATIENTS,

Petitioners,

—v.—

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES; MARI ROBINSON, EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD, IN THEIR OFFICIAL CAPACITIES,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE AMERICAN CIVIL LIBERTIES UNION, THE ACLU OF ALABAMA, AND THE ACLU OF WISCONSIN, IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST[1]

The American Civil Liberties Union ("ACLU") is a nationwide, non-profit, non-partisan organization with approximately 500,000 members dedicated to the principles of liberty and equality embodied in the Constitution and the nation's civil rights laws. The ACLU has long been committed to protecting the right to reproductive choice, and has participated in almost every critical case concerning reproductive rights to reach the Supreme Court. The ACLU of Alabama and the ACLU of Wisconsin are statewide affiliates of the national ACLU.

The ACLU and its affiliates represent clients in constitutional challenges to statutes that, like the Texas law at issue here, require physicians who provide abortions to obtain local hospital admitting privileges. The ACLU's clients in Alabama are Reproductive Health Services ("RHS"), which has for more than three decades been Montgomery, Alabama's only provider of abortion services, and its owner, June Ayers. Enforcement of the admitting privileges requirement in Alabama would have forced RHS to close. RHS's physicians have been on the obstetrics and gynecology staff and maintained admitting privileges at hospitals outside of Montgomery, but are unable to obtain admitting privileges at any hospital in Montgomery. The ACLU's client in Wisconsin is Milwaukee Women's Medical Services (also known as Affiliated Medical

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[1] Written consents to the filing of this brief have been submitted to the Clerk of Court. No counsel for a party authored this brief in whole or in part, and no person other than *amici* or their counsel made a monetary contribution to the preparation of the submission of this brief.

Services, or "AMS"), one of only four abortion clinics in Wisconsin. Enforcement of the admitting privileges requirement in Wisconsin would have forced AMS to close because its physicians—including its co-owner, Dr. Dennis Christiansen, who has been on the clinical faculty in the obstetrics and gynecology department at the University of Wisconsin Medical School in Madison—are unable to obtain admitting privileges at any hospital in Milwaukee.

SUMMARY OF ARGUMENT

The trial evidence and factual findings of the District Court establish in no uncertain terms that the provisions of Texas law at issue here would harm women under the guise of protecting them, and would undermine, not advance, the State's asserted interest in women's health. The Fifth Circuit disregarded that evidence entirely, holding that it was sufficient for the State to speculate that the law might further its interests, even though that speculation has been proven factually unfounded. That holding is a gross misapplication of this Court's precedent.

Amici submit this brief to make two points, one factual and one legal. First, the Texas District Court is not the first court to have made factual findings on the question of whether a statute banning physicians from performing abortions unless they obtain admitting privileges at a local hospital actually furthers the governmental interest in patient health. Shortly before the trial in Texas, district courts in Alabama and Wisconsin conducted bench trials in challenges to similar requirements.

Based on substantial trial records, the Alabama and Wisconsin courts made extensive factual findings that are entirely consistent with the Texas court's findings. All three courts found that there is no credible medical evidence that an admitting privileges requirement does anything to further the States' asserted health interest; that enforcement of such a requirement would significantly diminish the availability of abortion services, thus inflicting substantial harm on women; and that the expert witnesses who testified to the contrary on behalf of the States were unworthy of credence. The consensus among all three factfinders, based on their comprehensive review of extensive medical evidence, is that an admitting privileges requirement is "a solution in search of a problem, unless that problem is access to abortion itself." *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 953 (W.D. Wis. 2015), *aff'd sub nom. Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015) (quotation marks and citations omitted); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1378 (M.D. Ala. 2014) ("*Strange I*"); *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 685 (W.D. Tex. 2014), *aff'd in part, vacated in part, rev'd in part sub nom. Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir.), *modified*, 790 F.3d 598 (5th Cir.), *and cert granted*, 136 S. Ct. 499 (2015).

Second, under longstanding precedent, when constitutional rights are at issue, it does not suffice for the State merely to speculate that a law furthers its interests, and courts cannot accept such speculation where, as here, there is overwhelming record evidence to the contrary. Instead, the Court has for decades recognized that where a law

obstructs abortion access in the name of enhancing patient health, courts have the duty to determine whether the law in fact furthers the objective it purports to advance. The Court's decision in *Gonzales v. Carhart*—which emphasizes the importance of judicial review of the facts where constitutional rights are at stake, and which expressly examined whether the statute at issue in fact advanced the government's asserted interests—is fully consistent with that precedent. The decision below—which turns a blind eye to the overwhelming weight of medical evidence in favor of disproven speculation—represents an abdication of the role of the judiciary where constitutional rights are at stake, and is unfaithful to this Court's decisions.

ARGUMENT

I. IN THREE TRIALS ON ADMITTING PRIVILEGES REQUIREMENTS, DISTRICT COURTS HAVE FOUND THAT SUCH LAWS WOULD UNDERMINE RATHER THAN FURTHER THE STATE INTEREST IN WOMEN'S HEALTH AND WOULD SUBSTANTIALLY BURDEN WOMEN.

The record in this case amply supports the District Court's findings that the requirements challenged here lack a "credible medical or health rationale" and would impose a substantial obstacle to women seeking abortions in Texas. *Whole Woman's Health*, 46 F. Supp. 3d at 685. Moreover, these findings are completely consistent with the findings of the other trial courts that have examined the issue.

Shortly before the trial in this case, district courts in Alabama and Wisconsin conducted bench trials in challenges to recently enacted statutes that, like the challenged law in this case ("the Act"), imposed admitting privileges requirements on physicians providing abortions and that, also like the Act, would have substantially curtailed access to abortion by forcing clinics to close. In Alabama, over the course of a ten-day trial in May and June 2014, the court heard testimony from twenty-four witnesses, including twelve expert witnesses. *See generally Strange I*, 33 F Supp. 3d 1330; *Planned Parenthood Se., Inc. v. Strange*, 33 F Supp. 3d 1381 (M.D. Ala. 2014) ("*Strange II*"). In Wisconsin, the court conducted a four-day trial in May 2014 and heard testimony from nineteen witnesses, fifteen of them experts, including a court-appointed neutral medical expert.[2] *See generally Van Hollen*, 94 F Supp. 3d 949. Based on comprehensive evidentiary records, the Alabama and Wisconsin courts made extensive factual findings concerning whether an admitting privileges requirement would enhance patient health, and the obstacles that enforcing such a requirement would impose on women. Unlike the

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[2] Dr. Serdar Bulun, whom the Wisconsin court appointed as a neutral expert pursuant to Federal Rule of Evidence 706, is the Chair of the Department of Obstetrics and Gynecology at Northwestern University Feinberg School of Medicine. *Van Hollen*, 94 F. Supp. 3d at 954. The court chose Dr. Bulun "because of his expertise and qualifications in obstetrics and gynecology, insights into the [hospital privileges] credentialing process in light of his position as chair of the ob-gyn department at Northwestern, his lack of involvement in this particular lawsuit , and his general neutrality on issues surrounding abortion rights." *Id.* at 966.

Texas case, the cases in Alabama and Wisconsin concerned only an admitting privileges requirement, not an ambulatory surgical center requirement. However, these courts' findings concerning the safety of abortion relative to other outpatient medical procedures, and the effect that the forced closure of abortion clinics has on women seeking abortions, are relevant to both of the requirements at issue in this case.

The findings by the Texas District Court are consistent with, and amplified by, the findings in the Alabama and Wisconsin cases. In particular, the District Court in this case made five core findings related to the admitting privileges requirement that are reinforced by the trial findings in Alabama and Wisconsin. *First*, legal abortion is not only extremely safe, but is as safe as, or safer than, medical procedures routinely performed in outpatient settings by physicians who are not required to have admitting privileges. *Whole Woman's Health*, 46 F. Supp. 3d at 684. *Second*, requiring physicians to obtain admitting privileges does not improve continuity of care in the rare event that a patient experiences a complication that requires hospital-based treatment. *Id.* at 685. *Third*, the assertion that requiring physicians to obtain admitting privileges would enhance physician credentialing and oversight is not supported by credible evidence. *Id.* *Fourth*, admitting privileges requirements force abortion clinics to close, and the resulting reduction in access imposes severe and often insurmountable obstacles to women seeking an abortion. *Id.* at 682–84. *Fifth*, the expert testimony adduced in support of the admitting privileges requirement was not credible, reliable, or objective. *Id.* at 680 n.3. In

brief, the consensus among the factfinders is that an admitting privileges requirement would do nothing to further the objectives it purports to advance, and would instead inflict significant harm on women in the name of protecting their health.

A. All Three District Courts Found That Abortion Is Extremely Safe, And Is As Safe As, Or Safer Than, Other Medical Procedures Commonly Performed In Outpatient Settings By Physicians Who Are Not Required To Have Admitting Privileges.

The findings of the three district courts establish that abortion is not only extraordinarily safe, but is at least as safe as other medical procedures routinely performed in outpatient settings by physicians who are not required to have admitting privileges. *See Whole Woman's Health*, 46 F. Supp. 3d at 684; *Van Hollen*, 94 F. Supp. 3d at 970; *Strange I*, 33 F. Supp. 3d at 1364. As the Alabama and Wisconsin courts found, in the first trimester—when the vast majority of abortions in the United States take place—complications are "vanishingly rare," with hospitalization rates between 0.05 and 0.3%.[3] *Strange I*, 33 F. Supp. 3d at 1364; *accord Van Hollen*, 94 F. Supp. 3d at 967–68 (study of 233,805 medication abortions showed that

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[3] In all three cases, the States asserted that the complication rates in the medical literature are inaccurate, contending that complications from abortion are significantly underreported. In all three cases, where no witness substantiated that assertion at trial, the district courts rejected the assertion as unfounded. *See Whole Woman's Health*, 46 F. Supp. 3d at 684; *Strange II*, 33 F. Supp. 3d at 1394; *Van Hollen*, 94 F. Supp. 3d at 968–71.

0.06% of patients experienced a complication requiring hospitalization [4]; study of 11,487 first-trimester surgical abortions showed that no more than 0.052% of patients experienced a complication requiring hospitalization). [5] Beyond the first trimester, the complication rate increases, but "the risk of complications is still very low [even] for late-second trimester abortions." *Van Hollen*, 94 F. Supp. 3d at 968 n.18. Moreover, echoing the Texas District Court, these courts found that in the United States, the mortality rate from abortion is 0.0006%, which is 14 times lower than the mortality rate for childbirth. *Id.* at 968 (citing Elizabeth G. Raymond et al., *The Comparative Safety of Legal Induced Abortion & Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012)); *Strange I*, 33 F. Supp. 3d at 1364 (citing 2004–2008 data from the Centers for Disease Control and Prevention). As the Alabama court determined, a shot of penicillin is more than twice as likely to result in patient death than is a first-trimester abortion. *Strange I*, 33 F. Supp. 3d at 1364.

The Alabama and Wisconsin courts likewise reached findings comparable to the Texas District Court's concerning the safety of abortion relative to other outpatient procedures performed by physicians without state-mandated admitting privileges. *See*

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[4] *See* Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166, 169 (2013).

[5] *See* Tracy Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Public Health 454, 454–61 (2013).

Whole Woman's Health, 46 F. Supp. 3d at 684. The Wisconsin court found that "abortion is at least as safe as, and often much safer than, other outpatient procedures regularly performed" by physicians who are not required to have admitting privileges. *Van Hollen*, 94 F. Supp. 3d at 995. The court found that

> [a]bortions (both first and second trimester, and even post–16 week second trimester abortions) are safer or comparable in safety to other outpatient procedures. For example, operative colonoscopy has a complication rate of 5%, with major events requiring hospitalization in 2% of procedures. Egg retrieval for in vitro fertilization carries a severe complication rate of 0.72%. Diagnostic or operative hysteroscopy has a hospitalization rate ranging from 0.1 to 0.33%. Abortion is also comparable in safety or safer . . . [than] a vasectomy, which has a complication rate of 1 to 3%.
>
> . . . Drs. Bulun and Laube similarly testified to abortion being as safe as other outpatient gynecological procedures like cervical biopsies, endometrial biopsies, IUD insertions, and LEEP procedures, all of which routinely take place in the outpatient setting.

Id. at 971 (internal citations omitted). Unanimous expert testimony established that "admitting privileges are no more important for abortions than for other outpatient procedures," *Schimel*, 806 F.3d

at 915, yet "an admitting privileges requirement has never been imposed on *any* outpatient procedure other than the provision of abortion services," *Van Hollen*, 94 F. Supp. 3d at 965 (emphasis in original).

Similarly, in the Alabama trial, which focused on first-trimester abortions because no plaintiff in that case provided abortions beyond the first trimester, the court found that such procedures are comparable "[i]n terms of the difficulty of the procedure and probability of complications" to common gynecological procedures, like dilation and curettage, which are regularly performed in physicians' offices without an admitting privileges requirement. *Strange II*, 33 F. Supp. 3d at 1389; *see also Strange I*, 33 F. Supp. 3d at 1372 (finding that the State's expert Dr. Thorp performs dilation and curettage procedures in his office but lacks admitting privileges to perform gynecological surgery at any hospital). Moreover, like the District Court here, the Alabama court found that "the procedures performed at ambulatory surgical centers tend to be significantly more complex and invasive than a surgical abortion, which involves no cutting, or a medication abortion, which amounts to administering pills." *Strange II*, 33 F. Supp. 3d at 1389. In sum, the three courts unanimously found that abortion is not only extremely safe, but is at least as safe as procedures routinely performed in the outpatient setting by physicians without an admitting privileges requirement.

B. All Three District Courts Found That An Admitting Privileges Requirement Does Not Improve Continuity Of Care.

The Alabama and Wisconsin courts likewise concurred with the Texas District Court's rejection of the State's primary justification for the admitting privileges requirement, which was the contention that the requirement would further the State's interest in enhancing continuity of care. *See Whole Woman's Health*, 46 F. Supp. 3d at 685; *accord Strange I*, 33 F. Supp. 3d at 1372 ("No credible evidence supports the State's contention that continuity of care requires adopting [an admitting privileges requirement]."); *Van Hollen*, 94 F. Supp. 3d at 973 ("[A]t trial the *evidence* demonstrated that the admitting privileges requirement is unlikely to further continuity of care . . .") (emphasis in original).

As an initial matter, the Alabama and Wisconsin courts found not only that complications from abortion are extremely rare, but also that the vast majority of the complications that do occur are minor, and thus it is rarer still that a complication from an abortion would be treated at a hospital. *See Strange I*, 33 F. Supp. 3d at 1366; *Van Hollen*, 94 F Supp. 3d at 967–68; *accord Schimel*, 806 F.3d at 912. In those rare instances where complications do arise, many are appropriately managed in the clinic before the patient is discharged. *See Strange I*, 33 F Supp. 3d at 1366. For such complications, admitting privileges are irrelevant. *See id.* Similarly, for complications that manifest after a patient has been discharged—which will be the case for almost any complication that could result from a medication

abortion, *see Van Hollen*, 94 F. Supp. 3d at 976—most "are best treated with over-the-phone instructions, prescription medication from a pharmacy, or a follow-up visit to the abortion clinic," *Strange I*, 33 F. Supp. 3d at 1366. In these circumstances, as well, admitting privileges are irrelevant. *Id.* And for a more serious complication that arises after a patient has been discharged, the standard of care is for the patient to go to the closest emergency room, "which often will not be close to the clinic where the original procedure was performed." *Van Hollen*, 94 F. Supp. 3d at 976 (finding that at three clinics, the percentage of patients living outside the county where the abortion was performed was approximately 33%, 40%, and 89%); *Strange I*, 33 F. Supp. 3d at 1371–72; *accord W. Ala. Women's Ctr. v. Williamson*, ___ F. Supp. 3d ____, 2015 WL 4873125, at *14 (M.D. Ala. Aug. 13, 2015).[6] In such events, too, the courts found that an admitting privileges requirement would have no relevance to the patient's care, because the physician would not have privileges at a distant hospital, and such privileges would not satisfy the statutory requirement that the physician obtain privileges at a hospital within thirty miles of the clinic. *See Van Hollen*, 94 F. Supp. 3d at 976; *Strange I*, 33 F. Supp. 3d at 1371–72.

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[6] Following the trial on the admitting privileges statute, the Alabama court made additional, relevant findings in a related challenge to a regulation requiring abortion clinics either to employ physicians with admitting privileges or to establish a contractual relationship with an outside covering physician with such privileges. *See generally W. Ala. Women's Ctr.*, ___ F. Supp. 3d ___, 2015 WL 4873125.

Finally, the Alabama and Wisconsin courts found that an admitting privileges requirement does not further the interest in continuity of care even for the very small number of patients who need hospital care due to an abortion-related complication. That is because admitting privileges are not the means by which continuity of care is achieved in modern clinical practice. *See Strange I*, 33 F Supp. 3d at 1371; *Van Hollen*, 94 F. Supp. 3d at 974. Any claim to the contrary "falls outside the range of reasonable medical dispute in contemporary practice." *Strange I*, 33 F. Supp. 3d at 1378; *see also id.* at 1364 (citing *Gonzales v. Carhart*, 550 U.S. 124, 163–67 (2007)); *accord Van Hollen*, 94 F. Supp. 3d at 973.

Thus, based on the medical evidence, both courts determined that "the image of a treating physician in an outpatient setting accompanying her patient to the hospital, much less continuing treatment in the inpatient setting," was "contrary to modern hospital care."[7] *Van Hollen*, 94 F Supp. 3d at 974; *accord Strange I*, 33 F Supp. 3d at 1371. The Alabama court acknowledged that this "country-doctor approach" may "carry[] intuitive appeal," but the medical evidence showed that it simply "does not reflect the practice of 21st century medicine, as it

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[7] *See also Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 793 (7th Cir. 2013) ("The trend in the hospital industry is for the hospital to require the treating physician to hand over his patient who requires hospitalization to physicians employed by the hospital, rather than allowing the treating physician to continue participating in the patient's treatment in the hospital.").

relates to simple, low-risk surgeries and medication administrations."[8] *Strange I*, 33 F Supp. 3d at 1371.

Based on the medical evidence presented at both trials, the Alabama and Wisconsin courts instead found that continuity of care is provided in this setting by ensuring that hospital physicians treating a patient experiencing a complication have access to pertinent information about the outpatient physician's initial treatment. *See id.*; *Van Hollen*, 94 F. Supp. 3d at 975. As the Wisconsin court found, a "call from a treating physician would certainly be helpful" to ensure continuity of care, but admitting privileges "make[] no difference." *Van Hollen*, 94 F. Supp. 3d at 975; *see also W. Ala. Women's Ctr.*, ___ F. Supp. 3d ___, 2015 WL 4873125, at *14. In the event of an emergency complication requiring transfer to the hospital, the court found that a patient should be transferred via ambulance to a hospital emergency room, where the emergency room physicians "treat patients without regard to whether the treating physician has admitting privileges." *Van Hollen*, 94 F. Supp. 3d at 975–76. The court credited the testimony of Dr. Stephen Hargarten, Professor and Chairman of Emergency Medicine at the Medical College of Wisconsin and Chief of Emergency Medicine at Froedtert Hospital, who made clear that "it *makes no difference* whether the physician referring a patient to the emergency room has

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[8] As the Alabama court found, the State's Department of Public Health deemed an admitting privileges requirement medically "unnecessary." *Strange I*, 33 F. Supp. 3d at 1367. Indeed, when approached by the drafter of an earlier (and less stringent) admitting privileges bill, the Department opposed the requirement and requested that it be removed from the bill. *Id.*

admitting privileges or not," because in hospital emergency rooms, a patient is "treated without knowing whether an admitting physician is 'linked' with that patient." *Id.* (citations omitted, emphasis added); *see also id.* (finding that "[e]mergency room physicians are trained to manage obstetric-gynecological complications, and will consult with an ob-gyn when appropriate").[9]

Indeed, as the Alabama court found, far from furthering the asserted interest in patient health, enforcement of an admitting privileges requirement "would, in reality, do more to inhibit continuity of care than to promote it." *Strange I*, 33 F. Supp. 3d at 1372. The court found that because the enforcement of such a requirement would force clinics to cease providing abortion services altogether, *see* Section I.D, *infra*, many women would be compelled to travel to a different city, or out of state, to obtain an abortion, *Strange I*, 33 F Supp. 3d at 1372. Such decreased access to a local abortion provider would undermine continuity of care in two ways:

> [First,] [i]f she experienced a complication, which would be most likely to occur only after she returned home, she would have to seek treatment close to her home. Neither the doctor who performed the abortion nor the clinic's covering physician would be likely to have staff privileges at any

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[9] *See also Schimel*, 806 F.3d at 922 (No "witness for the defendants was able to cite a case in which a woman who had a complication from an abortion wasn't properly treated for it because her abortion doctor lacked admitting privileges.").

> hospital near her home . . . [Second,] in light of the challenges that many women face in traveling outside their home cities to secure an abortion, she would almost certainly be more likely to miss a scheduled follow-up visit.

Id.; *cf. Whole Woman's Health*, 46 F. Supp. 3d at 685–86 (rejecting the argument that it would further the interest in patient health for women to have to travel out of state to access an abortion). In short, none of the district courts found any credible evidence showing that an admitting privileges requirement would lead to improved continuity of care.

C. All Three District Courts Rejected The Assertion That An Admitting Privileges Requirement Furthers The Interest In Health Through Hospital Credentialing And Oversight.

At each trial, the State asserted that the admitting privileges requirement would enhance patient health by subjecting physicians who provide abortions to hospitals' credentialing and oversight, thereby helping to ensure the quality of physicians who provide abortions. All three district courts found that there was nothing beyond speculation to support that assertion. *See Whole Woman's Health*, 46 F. Supp. 3d at 685; *Strange I*, 33 F Supp. 3d at 1373–76; *Van Hollen*, 94 F. Supp. 3d at 977–80.

Among the principal reasons why an admitting privileges requirement would not lead to relevant scrutiny of physicians' credentials—and thus would do nothing to further the States' asserted

interest—is that while the hospital privileging process may indeed measure the quality of a physician's work performing the types of procedures that take place in the inpatient hospital setting, hospital privileging "does not measure the quality of care for those providers who exclusively practice in the outpatient setting," including physicians who perform abortions. *Van Hollen*, 94 F Supp. 3d at 978. Thus, when a hospital evaluates an application for privileges, it evaluates whether the physician is skilled at performing the specific procedures that are performed in the hospital, such as a hysterectomy, *see W. Ala. Women's Ctr.*, ___ F. Supp. 3d ___, 2015 WL 4873125, at *8, but does not measure whether the physician is skilled at performing procedures—like abortions—that are performed in an outpatient setting, not at the hospital, *Van Hollen*, 94 F. Supp. 3d at 978; *see also id.* ("In granting admitting privileges, hospitals are understandably concerned with an applicant's inpatient record of care."). Physicians whose practices do not focus on inpatient care, including physicians who provide abortions, have no record of inpatient practice to evaluate, and the hospital privileging process does nothing to measure the quality of the outpatient services the physicians provide. *See id.* at 978, 997. In the Wisconsin trial, for example, the evidence established that the "most experienced" provider of abortions in the State, who "has trained countless doctors in the procedures at the University of Wisconsin Medical School," did not have admitting privileges at a Milwaukee hospital. *Id.* at 978. The court found that this "in no way reflects a lack of quality or credentialing on his part," but instead reflected the fact that the hospital privileging process

does not measure the quality of a physician's outpatient medical care, or the physician's credentials to provide that care.[10] *Id.*

Indeed, the courts' findings make clear that the hospital privileging process is not only an unfit tool to measure the credentials of outpatient abortion providers, but is also a prejudicial one, because for reasons "having nothing to do with an individual doctor's quality of care," the hospitals may perceive that their "interests run counter to granting privileges to abortion providers." *Id.* at 979; *accord Whole Woman's Health*, 46 F. Supp. 3d at 685 ("doctors in Texas have been denied privileges for reasons not related to clinical competency"). Specifically, the Wisconsin court found that because of the extremely low rate of serious complications from abortion, physicians who provide abortions "unquestionably offer little chance of hospital referrals," which is often a criterion for admitting privileges. *Van Hollen*, 94 F. Supp. 3d at 979. They also create "a real risk of controversy" due to the stigma associated with abortion, decreasing their chance of obtaining admitting privileges. *Id.*; *see also Strange I*, 33 F. Supp. 3d at 1345 (finding many

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[10] Moreover, even if the hospital privileging process were a relevant measure of the quality of a physician's outpatient medical care, the courts also found that there is "no reason why the requirement should be limited to hospitals within a thirty-mile radius if the reason for this requirement is simply a 'stamp of approval.'" *Van Hollen*, 94 F. Supp. 3d at 977; *accord Schimel*, 806 F.3d at 915; *Strange I*, 33 F. Supp. 3d at 1373. Many of the physicians in these cases have privileges at a hospital, but not one within thirty miles of the clinic. *See, e.g.*, *Van Hollen*, 94 F. Supp. 3d at 977; *Strange I*, 33 F. Supp. 3d at 1373.

hospitals have minimum admissions requirements to obtain privileges, and some hospitals oppose abortion). Accordingly, the court found that the hospital privileging process is neither a relevant nor a neutral quality metric for outpatient abortion providers, and thus the admitting privileges requirement would not advance the State's interest in monitoring doctors' credentials. *See Van Hollen*, 94 F. Supp. 3d at 977–79.

Nor was there credible evidence to support the States' related assertion that "the threat of losing staff privileges would be an effective incentive for doctors to provide high-quality abortion care," and would therefore provide a form of ongoing hospital oversight over abortion providers. *Strange I*, 33 F. Supp. 3d at 1374–76. The district courts reviewed the medical evidence and determined that the contention rested on nothing but "speculation." *Id.* at 1376; *accord Van Hollen*, 94 F. Supp. 3d at 979. As the Wisconsin court found, under existing law, it was *already* the case absent an admitting privileges requirement that "a failure to communicate with the receiving hospital would constitute patient abandonment or substandard medical care, and would subject the provider to disciplinary actions by the Medical Examining Board." *Van Hollen*, 94 F. Supp. 3d at 979. The evidence made plain that any speculative added benefit of hospital oversight would be "incremental at best." *Id.*; *accord Strange I*, 33 F Supp. 3d at 1376. As with the continuity of care justification, all three district courts found that there was not credible evidence supporting the contention that an admitting privileges requirement would enhance credentialing and oversight of physicians providing abortions.

D. All Three District Courts Found That Admitting Privileges Requirements Force Abortion Clinics To Close, Imposing Severe And Insurmountable Obstacles To Women Seeking An Abortion.

Not only did the courts find that an admitting privileges requirement fails to further the States' interest, but all three courts further found that it is impossible for many abortion providers to comply with such a requirement, and that the resulting loss of access to abortion would impose insurmountable obstacles to abortion access and severely harm women seeking abortions. *See Whole Woman's Health*, 46 F. Supp. 3d at 681–84; *Strange I*, 33 F. Supp. 3d at 1377–78; *Van Hollen*, 94 F. Supp. 3d at 989–95.

The courts found that for reasons having nothing to do with the physicians' ability to provide safe medical care, *see* Section I.C, *supra*, abortion clinics in Alabama and Wisconsin could not satisfy the admitting privileges requirement and would be forced to stop providing abortions. Specifically, the Alabama court found that enforcement of the admitting privileges law would "wipe out the availability of abortion services in Montgomery, Birmingham, and Mobile," leaving two clinics in the state. *Strange I*, 33 F. Supp. 3d at 1355, 1335. Moreover, after trial, the doctor at one of the two remaining clinics retired and the physician hired to replace him—who was on the faculty, and holds admitting privileges, at Northwestern School of Medicine in Chicago—could not obtain admitting privileges in Alabama, leaving just one physician in

all of Alabama who has admitting privileges and provides abortions. *W. Ala. Women's Ctr.*, ___ F. Supp. 3d ___, 2015 WL 4873125, at *1–4. In Wisconsin, absent preliminary injunctive relief, the admitting privileges statute would have closed two of the state's four abortion clinics and reduced the capacity of a third clinic by half. *Van Hollen*, 94 F. Supp. 3d at 986–89. Although some of the physicians at two clinics obtained privileges during the pendency of the litigation, "those privileges were granted conditioned on future admission of a certain number of patients," a condition the court found the physicians were unlikely to meet because the practice of abortion leads to so few complications. *Id.* at 988–89. The Alabama and Wisconsin courts further found that due to factors like "violence against and harassment of abortion providers" and "significant regulatory barriers to entry" for new providers, "it is most unlikely" that any new providers would take their place. *Strange I*, 33 F. Supp. 3d at 1348–55; *Van Hollen*, 94 F. Supp. 3d at 981–83 (noting the "precarious availability" of abortion providers nationwide and in Wisconsin).

The courts found that this sweeping reduction in the availability of abortion services would, in at least three ways, significantly harm women and obstruct access to abortion. First, as in Texas, *see Whole Woman's Health*, 46 F. Supp. 3d at 682, the evidence established that the elimination of abortion services at clinics where physicians could not obtain privileges would overwhelm the capacity of the remaining clinics, which in turn would impose severe burdens on women, *see Van Hollen*, 94 F. Supp. 3d at 990; *Strange I*, 33 F. Supp. 3d at 1361–62; *W. Ala. Women's Ctr.*, ___ F. Supp. 3d ___, 2015 WL 4873125,

at *11. The Wisconsin court found that the reduced availability of abortion services would result in "an eight to ten week wait time" at the few remaining clinics. *Van Hollen*, 94 F Supp. 3d at 990. As the court recognized, given the time-sensitive nature of abortion, such delay is untenable—the court found that "[t]hese wait times have obvious ripple effects on the availability for all abortions, including . . . the safest, early-term procedures." *Id.* The court found:

> Necessarily, women will likely be pushed out of the window for receiving medication abortions . . . and could be pushed entirely out of the pre-viability zone, preventing some women from having an abortion at all. Even if not out of the zone of pre-viability, the delay may result in some women not being able to have an abortion until the second trimester, when abortions are not only more expensive, but past the point where some women are comfortable having an abortion. Increased wait times will obviously also mean that women are receiving abortions later in gestation, which in turn increases health risk.

Id. (internal citations omitted).

Second, the courts found that the reduced availability of abortion providers would increase the distance many women would be forced to travel to obtain an abortion, and that such travel burdens would prevent a significant number of women—particularly poor women (who comprise the majority of abortion patients nationwide)—from obtaining an

abortion at all. *Id.* at 991–92; *Strange I*, 33 F. Supp. 3d at 1356–60; *accord Whole Woman's Health*, 46 F. Supp. 3d at 682–83. Both the Alabama and Wisconsin courts reviewed "substantial statistical evidence" proving that increased travel distance prevents women from obtaining an abortion. *Strange I*, 33 F. Supp. 3d at 1356; *accord Van Hollen*, 94 F Supp. 3d at 991–92. Among the "major example[s] of this effect" is a 2011 study of the impact of a Texas law "that effectively eliminated, for a two-year period, availability of abortions after 16-weeks gestational age within the State," and thereby imposed an average 200-mile travel distance for women who had to travel out of state to obtain an abortion after 16 weeks. *Strange I*, 33 F Supp. 3d at 1356; *accord Van Hollen*, 94 F. Supp. 3d at 992. The increased travel distance prevented more than half of affected women from obtaining an abortion at all. *Strange I*, 33 F. Supp. 3d at 1356; *Van Hollen*, 94 F. Supp. 3d at 992. Other studies relied upon by both courts established that far smaller increases in travel distance likewise block women from obtaining an abortion.[11] *Strange I*, 33 F. Supp. 3d at 1356–60 (100-mile increase in travel distance reduces abortion rate by 22%, and 50-mile increase prevents low-income urban women from obtaining abortions); *Van*

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[11] The Alabama court explained that the Fifth Circuit's "simplistic legal rule" that travel distances short of 150 miles cannot be unduly burdensome, *see Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 598 (5th Cir. 2014), is not only contradicted by scientific evidence, but is contrary to *Casey*'s fact- and record-specific approach to the effect of travel distance on abortion access. *Strange I*, 33 F Supp. 3d at 1359–60 (citing *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 887 (1992)).

Hollen, 94 F. Supp. 3d at 992; *accord W. Ala. Women's Ctr.*, ___ F. Supp. 3d ___, 2015 WL 4873125, at *9 (data showed that temporary closure of clinic 60 miles from next-closest abortion provider resulted in "hundreds fewer women" obtaining abortions).

Third, the courts found that barriers to accessing a safe and legal abortion cause women to resort to medically unsupervised self-abortion. *Strange I*, 33 F. Supp. 3d at 1362–63; *Van Hollen*, 94 F. Supp. 3d at 994; *see also Whole Woman's Health*, 46 F. Supp. 3d at 684. As Dr. Bulun, the court-appointed expert in Wisconsin, explained, "[e]pidimiologic data indicate an inverse relationship between the availability of legal abortion and resorting to illegal abortion associated with remarkable increased risks of death or morbidity," including increased risk of "septic abortion, uterine infection, pelvic abscess, loss of uterus and/or ovaries [and] infertility." *Van Hollen*, 94 F. Supp. 3d at 979 n.31 (internal quotation marks and citation omitted); *accord Strange I*, 33 F. Supp. 3d at 1363 (danger of women "attempt[ing] surgical abortions on themselves" poses risk of "severe infections, including gangrene of the uterus," and death) (internal quotation marks and citation omitted). The Wisconsin court credited Dr. Bulun's opinion that "significantly limiting access to abortions . . . is an unacceptable experiment for women's health." *Van Hollen*, 94 F. Supp. 3d at 994; *see also Strange I*, 33 F. Supp. 3d at 1377–78 ("By eliminating abortion services in the three cities, the requirement . . . . create[s] a significant risk that some women would pursue dangerous, illegal abortions.").

E. All Three District Courts Found That The Expert Testimony Supporting The Restrictions Was Not Credible, Reliable, Or Objective.

Finally, in all three cases, the courts found that the primary expert witnesses who testified in support of the admitting privileges requirement were not credible, reliable, or objective. In Texas, the District Court made adverse credibility findings as to the State's four principal expert witnesses and determined that their testimony was entitled to diminished weight. *See Whole Woman's Health*, 46 F. Supp. 3d at 680 n.3. The court found that "at a very minimum," a non-physician consultant for the State, Vincent Rue, "had considerable editorial and discretionary control over the contents of the experts' reports and declarations," which undermined the experts' reliability and objectivity.[12] *Id.*

Two of those experts, Dr. James Anderson and Dr. Peter Uhlenberg, testified at all three admitting privileges trials, and the Alabama and Wisconsin courts similarly discredited their testimony. *See Strange II*, 33 F. Supp. 3d at 1386–88, 1395; *Van Hollen*, 94 F Supp. 3d at 973 n.24, 976 n.27, 992

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[12] As noted by the Wisconsin court, *see Van Hollen*, 94 F. Supp. 3d at 973 n.24, Rue himself has been discredited as a testifying expert because he lacked "academic qualifications and scientific credentials"; his testimony "was devoid of analytical force and scientific rigor"; "his admitted personal opposition to abortion, even in cases of rape and incest, suggests a possible personal bias"; and because he sought to testify on subjects about which he lacked expertise, *Planned Parenthood of Se. Pa. v. Casey*, 744 F. Supp. 1323, 1333–34 (E.D. Pa. 1990), *aff'd in part*, 947 F.2d 682 (3d Cir. 1991), *aff'd in part*, 505 U.S. 833.

n.46. Specifically, the Alabama court found that Dr. Anderson—a family medicine and emergency room doctor whose testimony in defense of the admitting privileges requirement was at the heart of each State's case—signed his name to an expert report written entirely by Rue, whom Dr. Anderson professed not to know, without so much as checking the report's contents. *See Strange II*, 33 F. Supp. 3d at 1386–88. The court explained that there were

> three explanations for Anderson's willingness to sign his name to a report written by a man about whom he knows so little, to do so without even checking its contents, and then to represent the opinions in it as his own: either he has extremely impaired judgment; he lied to the court as to his familiarity with Rue; or he is so biased against abortion that he would endorse any opinion that supports increased regulation on abortion providers. Any of these explanations severely undermines Anderson's credibility as an expert witness.

Id. at 1388. Similarly, the Wisconsin court found that Rue, "who has been discredited by other courts because of his lack of analytical rigor and possible personal bias . . . . ghost wrote or substantively edited portions of some of defendants' expert reports," including Dr. Anderson's. *Van Hollen*, 94 F Supp. 3d at 973 n.24; *see also id.* at 976 n.27 (Dr. Anderson's bias undercut his credibility).

In addition, as in Texas, the Alabama and Wisconsin courts discredited the opinions of Dr.

Uhlenberg, who testified in all three cases that enforcement of the admitting privileges requirement would not burden women seeking abortions. Because Dr. Uhlenberg's opinions were based on an "unsophisticated" methodology and relied upon "statistical analyses with serious methodological flaws," his testimony was consistently found unworthy of credence. *Strange II*, 33 F Supp. 3d at 1395; *accord Van Hollen*, 94 F. Supp. 3d at 992 n.46 (placing "little weight" on Dr. Uhlenberg's testimony and noting his bias).

The Alabama and Wisconsin courts' concerns over the reliability and credibility of witnesses testifying in support of the admitting privileges requirement extended well beyond Drs. Anderson and Uhlenberg. For example, both courts found that Dr. John Thorp—upon whose declaration the Fifth Circuit relied heavily in *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 748 F.3d 583, 592–93 (5th Cir. 2014)—"displayed a disturbing apathy toward the accuracy of his testimony." *Strange II*, 33 F. Supp. 3d at 1394; *Van Hollen*, 94 F. Supp. 3d at 969 (Dr. Thorp's testimony resembled "advocacy," not "expert opinion"). In all three cases, the experts who testified in defense of the statutes largely were found to lack "objectivity and reliability." *Whole Woman's Health*, 46 F. Supp. 3d at 680 n.3.

II. WHEN CONSTITUTIONAL RIGHTS ARE AT STAKE, COURTS HAVE THE DUTY TO DETERMINE WHETHER THE LAW ACTUALLY FURTHERS THE GOVERNMENT'S INTERESTS.

As the preceding discussion makes plain, each of the three district courts found not only that enforcement of an admitting privileges requirement would significantly harm women seeking abortion services, but also that the trial evidence overwhelmingly refuted the State's unsupported assertion that the requirement would enhance patient health. The Fifth Circuit nevertheless concluded that it is irrelevant that the evidence in the Texas trial conclusively established that the Act would not further the State's interest, because it believed that a law burdening abortion may be upheld if it is possible to speculate that the law might advance the State's interest in patient health. *See Whole Woman's Health v. Cole*, 790 F.3d 563, 584 (5th Cir. 2015). This position—that courts must blind themselves to evidence showing that a law burdening constitutional rights does not in fact further the state interest it purports to advance—is squarely at odds with this Court's precedent and incompatible with the constitutional protections afforded to fundamental rights.

This Court has long made clear that when constitutional rights are at stake, the State must do more than speculate that a law might further its interests, and that courts cannot accept such speculation in the face of evidence to the contrary. For example, in the context of a governmental restriction on commercial speech, it does not suffice

for the government to invoke interests that "are substantial in the abstract." *Edenfield v. Fane*, 507 U.S. 761, 770 (1993). Instead, the government "must demonstrate that the harms it recites are real and that its restriction will in fact alleviate them to a material degree." *Id.* at 770–71 (citations omitted). Similarly, in constitutional challenges to state election laws that burden associational and voting rights, courts "must identify and evaluate the precise interests put forward by the State as justifications for the burden imposed by its rule," and "must not only determine the legitimacy and strength of each of those interests" but must also "consider the extent to which those interests make it necessary to burden the plaintiff's rights." *Anderson v. Celebrezze*, 460 U.S. 780, 789 (1983), *cited with approval in Casey*, 505 U.S. at 873–74; *accord Norman v. Reed*, 502 U.S. 279, 288–89 (1992), *cited with approval in Casey*, 505 U.S. at 873–74. Likewise, in evaluating equal protection claims, courts review the evidence to determine whether a classification actually furthers the state interest the law purports to advance. *See, e.g., Craig v. Boren*, 429 U.S. 190, 199–200 (1976) (although "the protection of public health and safety represents an important function of state and local governments," the state's "statistics in our view cannot support the conclusion that the gender based distinction closely serves to achieve that objective"). And where the government seeks to intrude upon a criminal defendant's liberty interest against the forced administration of antipsychotic medication to render the defendant competent to stand trial, courts have the duty to examine whether "involuntary medication will significantly further . . . [important] state interests." *Sell v. United States*, 539 U.S. 166,

181 (2003) (emphasis omitted). Although the Court employed different doctrinal frameworks in resolving these cases, each case reiterated the relevant core principle—that it is the duty of courts to review whether a law that burdens fundamental rights actually furthers the government's interests.

The decision below rests on the faulty premise that there is an abortion exception to this bedrock principle of constitutional law. There is not, and this Court has never held otherwise. Far from accepting bare speculation that a law restricting abortion might advance the government's objectives, the Court has continuously examined whether such laws further the government's interests. *See Gonzales*, 550 U.S. at 146 (courts "must determine whether [the law] furthers" the government's asserted interest); *Casey*, 505 U.S. at 900–01 (finding that recordkeeping and reporting requirements further the state interest in patient health); *Simopoulos v. Virginia*, 462 U.S. 506, 516–18 (1983) (reviewing "accepted medical standards" to determine whether regulation of second-trimester abortions advanced the state interest in patient health and safety); *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 434–38 (1983) (reviewing medical data to determine whether regulation "is reasonably designed to further" the compelling interest in patient health), *abrogated on other grounds by Casey*, 505 U.S. at 882; *Planned Parenthood Assn. of Kan. City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 481–82 (1983) (same); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 77–79 (1976) (reviewing evidence showing whether ban on then-common method of second-trimester abortion would advance the interest in patient health). Indeed, the Court has undertaken

such examination with particular care in the context of laws that purport to enhance patient health. As the Ninth Circuit has explained:

> In the context of a law purporting to promote fetal life, whatever obstacles that law places in the way of women seeking abortions logically serve the interest the law purports to promote—fetal life—because they will prevent some women from obtaining abortions. By contrast, in the context of a law purporting to promote maternal health, a law that is poorly drafted or which is a pretext for anti-abortion regulation can both place obstacles in the way of women seeking abortions *and* fail to serve the purported interest very closely, or at all.

Planned Parenthood Ariz. v. Humble, 753 F.3d 905, 912 (9th Cir. 2014) (citation omitted).

The Court's decision in *Doe v. Bolton* is instructive. 410 U.S. 179 (1973). There, the Court reviewed medical evidence to determine whether a law that prohibited the performance of any abortion outside of a hospital would in fact further Georgia's unquestionably important interest in patients' health. *Id.* at 193–95. Based on the fact that Georgia imposed "no restriction on the performance of nonabortion surgery" outside of hospitals, *id.* at 193, and data showing that "facilities other than hospitals are entirely adequate to perform abortions," the Court determined that the requirement did not materially advance the State's health interests and struck it down, *id.* at 195; *see*

also Casey, 505 U.S. at 874–75 (in describing the undue burden standard, citing *Doe* among "the Court's early abortion cases [that] adhered to [the correct] view").

The Court's most recent jurisprudence is entirely consistent with this approach. In *Gonzales*, the Court emphasized that courts have the duty to review the factual evidence "in these cases" because "[u]ncritical deference" to the government is unacceptable "where constitutional rights are at stake." 550 U.S. at 165–66. Consistent both with that duty and with the Court's approach in prior decisions, *Gonzales* makes clear that courts "must determine whether [an abortion regulation] furthers" the government's asserted interest. *Id.* at 146. The Court undertook that inquiry in significant detail, examining not only congressional fact-finding, but also the trial testimony, *id.* at 159, and ultimately determined that the statute in that case in fact "further[ed] the Government's objectives," *id.* at 158. The Fifth Circuit's conclusion that courts have no role to play in determining whether a law burdening the right to abortion in fact furthers the governmental interests it purports to serve is unfaithful both to what the Court said and what it did in *Gonzales*.

Nor does the discussion of the significance of "documented medical disagreement" in *Gonzales* aid Respondents here. *Id.* at 162. In *Gonzales*, the Court explained that where a court determines that there is substantial and documented disagreement in the medical community over whether a regulation requiring physicians to use one abortion procedure in lieu of another would have any effect on women at

all, the court should not override the legislature's judgment. *Id.* at 162–64. But such real and significant medical disagreement exists only where there is "substantial and objective medical evidence" demonstrating that "the State had considerable support for its conclusion," *Stenberg v. Carhart*, 530 U.S. 914, 969 (2000) (Kennedy, J., dissenting), and courts have the duty to review the facts to determine whether such substantial, objective medical evidence exists, *see Gonzales*, 550 U.S. at 162, 165–66 (reviewing the "testimony in the District Courts" and the "evidence presented in the District Courts"). In *Gonzales*, this Court found that there was substantial medical disagreement where "[t]he three District Courts that considered the Act's constitutionality appeared to be in some disagreement on [the] central factual question," where there was "a division of opinion among highly qualified experts," and where the government's "expert witnesses reasonably and effectively refuted" many of the plaintiffs' assertions. 550 U.S. at 162 (quotation marks and citations omitted). But this case presents precisely the opposite scenario to that in *Gonzales*—here, there was a consensus among the three district courts that the admitting privileges requirement would not further the States' interests, *see* Sections I.A, I.B, and I.C, *supra*, and the State's principal expert witnesses who testified otherwise were consistently found unworthy of credence, *see* Section I.E, *supra*. Thus, contrary to the decision below, nothing in *Gonzales* authorizes a court to disregard that evidence and to rely on speculation that the evidence overwhelmingly refutes.

Moreover, the Fifth Circuit compounded its misplaced reliance on *Gonzales* by ignoring one of the

central premises of that decision—that deference in the face of genuine medical uncertainty was appropriate there precisely because "[a]lternatives [were] available to the prohibited procedure." 550 U.S. at 164. The Court determined in *Gonzales* that the law at issue would not obstruct abortion access because "standard medical options [were] available" to all affected women. *Id.* at 166. But once again, as the District Court here found, the opposite conclusion is compelled in this case, because enforcement of the challenged statute would drastically reduce women's access to abortion in Texas—just as women's access to abortion would be drastically reduced by parallel laws in other states. *See* Section I.D, *supra*. Similarly, in *Gonzales*, the Court was careful to note that "preenforcement, as-applied challenges to the Act" remained available for women with particular conditions that necessitated the use of a banned procedure. *Gonzales*, 550 U.S. at 167. No such alternative remedy exists for women in Texas. A woman who can show that the Act will prevent her from having an abortion at all will have no remedy once the clinic has been forced to shut its doors because it cannot comply with the requirements. Given the significant and far-reaching burdens, it was plainly incorrect for the Fifth Circuit to rely upon the government's speculation about the law's benefits in the face of overwhelming evidence establishing that the speculation is unfounded.

Indeed, the Fifth Circuit's approach is not only unfaithful to this Court's precedent, but is at odds with the very premise that a woman has a constitutionally protected right to decide to have an abortion at all. Under the Fifth Circuit's approach, a state can enact a law that harms many women and

obstructs the exercise of fundamental rights, as the Act indisputably does, *see Whole Woman's Health*, 790 F.3d at 588, and courts must uphold it even where the evidence establishes that the law does nothing to further a valid state interest. This cannot be, and is not, the law. *See, e.g.*, *Schimel*, 806 F.3d at 921 ("[A] statute that curtails the constitutional right to an abortion . . . cannot survive challenge without evidence that the curtailment is justifiable by reference to the benefits conferred by the statute."). The justification for a law that infringes on constitutional rights cannot rest on the government's mere invocation of a non-arbitrary interest and speculation that the law might be rationally related to that interest. Were that the rule, constitutional protections would be all but meaningless. *Cf. District of Columbia v. Heller*, 554 U.S. 570, 628 n.27 (2008) ("[o]bviously," an assurance against irrationality would not suffice to justify a law that burdens fundamental rights).

CONCLUSION

For the reasons set forth above, and in the Brief for the Petitioners, the judgment below should be reversed.

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